RESET FORM RESET FORM

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the office of the Surgeon General

REPORT TITLE **EMERGENCY DEPARTMENT DISCHARGE INSTRUCTIONS - ADULT** | OTSG APPROVED *(Date)* (YYYYMMDD)

The examination and treatment you received has been rendered on an emergency basis and is not intended to substitute or provide complete medical care. Often additional care is needed and this will be provided by the general or specialty clinic to which you have been referred. All tests will be reviewed by doctors who specialize in their interpretation at a later date and you will be contacted if there are findings different from the emergency department.

Diagnosis: _____

Discharge instructions provided (check/circle one)

- ☐ Abdominal pain
- ☐ Allergic reaction
- ☐ Asthma
- ☐ Upper back/neck pain
- ☐ Low back pain
- ☐ Behavioral
- ☐ Chest pain
- ☐ Conjunctivitis
- ☐ Dehydration
- ☐ Vomiting/diarrhea
- ☐ Headache
- ☐ Head injury
- ☐ Heat exhaustion
- ☐ Influenza
- ☐ Kidney stone
- ☐ Seizure
- ☐ Sprains/strains/bruises/fractures
- ☐ Threatened miscarriage
- ☐ Urinary tract infection
- ☐ Viral upper respiratory infection
- ☐ Other (specify):_____

☐ Wound care/burn care: Keep the wound clean. Apply the ointment and change the dressing ____ times per day. If you note swelling, pus, foul oder, fever, redness, increased pain, or have any concerns return to PCM or ED.

☐ Stitches/staples removed in ____ days by PCM/ED.

☐ Wound checked in ____ days by PCM/ED

☐ Packing changed in ____ days by PCM/ED

☐ Metformin and IV contrast: Your medication list includes metformin. (Glucophage). During your stay in the ED you received intravenous contrast for a CT scan. You should stop your metformin for 48 hours and follow-up with your primary care provider to prevent possible interactions between the metformin and the IV contrast. Continue to monitor your blood glucose as normal. If you notice that your glucose is running high or you have symptoms of low blood sugar call yout PCM or return to the ED.

*** PCM is primary care physician**
**** ED is emergency department**

Additional Instructions: _____

_____

_____

Medications: ☐ Medication reconciliation completed by ED provider and list given to patient.
☐ Medication reconciliation NOT indicated.

Please make the following changes to your home medications: _____

Your provider has prescribed the following medications: _____

_____

All medications have potential side effects and medications can interact with each other. After you review your medications, notify an ED staff member or the pharmacy if you have questions.

☐ You have been prescribed medications which decrease your alertness. Do not drive or perform activity where alertness is required.

Follow-up:

☐ Make an appointment in _____ days at your primary care managers clinic, or sooner if you become worse.

☐ A physician was consulted to continue your care in the _____ clinic. Please call for an appointment.

☐ TRICARE appointment number 1-866-299-4234 or 573-596-1490 ☐ Front Desk 596-0035 ☐ Family Practice 596-1765

☐ Internal Med 596-1600 ☐ Ozark St Robert 596-0064 ☐ CTMC 596-1680 ☐ Victory 596-1760 ☐ OB/GYN 596-1770 ☐ Ortho 596-1764

☐ Podiatry 596-1767 ☐ EENT 596-0048 ☐ Gen Surg 596-1769 ☐ Phy Therapy 596-1707 ☐ Behavioral Med 596-0522 ☐ Social Work 596-0521

The patient and/or the representative verbalizes/demonstrates understanding of medications, treatment plans, pain management and follow-up care. I understand and have received a copy of my instructions regarding my medical care and follow-up care as noted above. I understand that if there is a serious change in my condition I should contact my regular clinic or return to the ED.

Patient/Representative Signature: _____ Date: _____

ACCIDENTAL INGESTION? Call 911 or Poison Control 1-800-222-1222

SUICIDE ON YOUR MIND? Help is available. Notify ED staff member, Military Police, or Military One Source 1-800-342-9647

YOUR FEEDBACK IS IMPORTANT TO US! Please complete and return the survey you receive in the mail regarding your ED visit.

PREPARED BY (Signature & Date)	DEPARTMENT/SERVICE/CLINIC	Date *(YYYYMMDD)*
	GLWACH ER	

Patients Identification *(For typed or written entries give: Name- Last, First, Middle; grade; date; hospital or medical facility)*

☐ **HISTORY/PHYSICAL** ☐ **FLOW CHART**

☐ **OTHER EXAMINATION OR EVALUATION** ☐ **OTHER PIXIS** *(Specify)*

☐ **DIAGNOSTIC STUDIES**

☐ **TREATMENT**